

## Introduction to Cognitive Behavioral Therapy

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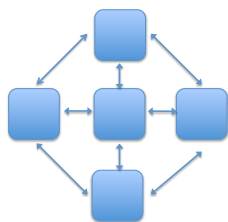
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## Studies

- CBT is an effective treatment.
- Commonly, people treated with medication alone still have some symptoms. Results from several studies indicate CBT plus medications more effective than medication alone.
- Reoccurrence of mood & anxiety disorders is common; people who have had CBT, with or without medication, report lower relapse rates.

## The CBT model: understanding mental health problems as an interplay of variables

- Interpersonal/environmental context
- Physiology
- Behavior
- Cognitions
- Emotions



## First Principal Concept

- There is a reciprocal interaction between what we think, how we feel (physical and emotional reactions), and how we behave.
  - The meaning we attach to an event or an incident will influence how we feel.
  - How we interpret our feelings and the meanings of events can drive how we respond. “Events” include how the environment responds to our behavior.

## Second Principal Concept

- What we learn in early childhood, through our interactions with our environment and significant people in our lives (consider cultural context, family history, meeting developmental milestones), leads to development of “schemas” or “core beliefs” (templates for processing info)
  - People have several schemas
  - Schemas can be positive or negative, adaptive or maladaptive
  - Events are filtered through these schemas
  - “Automatic thoughts” arise from these schemas

## Third Principal Concept

- CBT model considers most dysfunctional emotional states to be the result of, & exacerbated by, misinterpretation and erroneous attributions attached to triggering events.
  - “Dysfunctional” refers to those feelings which are not life preserving, get in the way of desired outcomes, increase non-productive conflict.

### Fourth Principal Concept

- Not all unpleasant emotions are dysfunctional, and not all pleasant emotions are functional.
  - “Functional” emotions are life preserving, productive for achieving desired outcomes

### Cognitive disturbances common in depression

- Thoughts of self: helpless, worthless, unlovable, incompetent
- Thoughts of environment:
  - The “present” is all challenge that cannot be overcome
  - The “future” will be more of the same
  - “What’s the use?”
- Thoughts of others:
  - They can’t or don’t understand
  - They can’t or won’t help
  - & I’m not worth it anyway

### Behavioral disturbances common in depression

Withdrawal

Avoidance

Inhibition

Increasingly narrow range of activity

### Principles of Cognitive Therapy

- Case formulation (initial & ongoing)
  - (1) General presenting problem (collaboratively arrived at). “Collaborative empiricism” to find out:
  - (2) What is manifested behaviorally (doing) and physiologically
  - (3) What emotions are involved
  - (4) What is the current thinking
  - (5) What are key developmental events along the way, and what is the interpretation of these events
  - (6) What are the enduring patterns of the client’s (family’s) interpretation?

### Principles of CBT continued...

- Solid therapeutic alliance (engagement)
- Collaboration & active participation
- Treatment is time limited, goal-oriented & problem focused
- Structured sessions
  - Check-in
  - Collaboratively set the agenda (include homework review)
  - Work the agenda
  - Periodic summaries
  - Set homework

### Principles of CBT continued...

- Cognitive interventions using “Socratic dialogue,” asking questions that
  - elicit and illuminate the meanings that are placed on events
  - examine the data that support the meaning, and the data that does not support the meaning
  - identify alternative ideas that take into account all the data
- Behavioral interventions
  - for depression: scheduling of pleasurable activities, behavioral activation
  - for anxiety: exposure to feared situations
  - For both, trying out behaviors based on more balanced cognitions
- Homework (usually, but not always)

### Cognitive targets for intervention with persons with depression

- Teach the client to identify events, thoughts, and moods
- Teach the client to recognize the interaction of thoughts and moods/feelings
- Teach the client how to recognize and challenge distorted thinking by guided exploration:
  - What are my automatic thoughts? What's the one that's the most important (the "hot thought")?
  - What's the evidence that supports the hot thought?
  - What's the evidence that does not support the hot thought?
  - What is a more balanced thought that takes into account both the supporting and disconfirming evidence?

### Sample Thought Record

Situation	Mood	Automatic Thoughts (circle the most imp. one)	Evidence For the circled thought	Evidence Against the circled thought	More balanced (taking into account all the evidence)

CBT helps a client recognize and challenge distorted thinking, and then act (behave) in a way that reflects more "balanced" thinking.

NOT about the therapist "proving" the client is wrong

NOT about ignoring/denying realistic assessments of life problems and only "thinking happy thoughts"

### CBT is about Collaboration & Guided Discovery

...helping clients widen their "filter," being curious about evidence that might or might not confirm an assumption and examining what other data are there to attend to.



More balanced appraisals of situations  
Responses based on these appraisals

- Discover new possibilities by considering all the evidence (not just what reinforces the depressed interpretation); identify more balanced appraisal.
- Try out new behaviors/responses based on the more balanced appraisal.

### Flexibility in CBT

- Cultural considerations
  - Strategies for engagement
  - Strategies for collaboration
  - Some questions that might seem reasonable in one cultural context might seem rude in others; assess how direct or indirect to be
- Stage in therapy
  - With children & adults, clinicians may be more directive in the beginning, as clients are learning the CBT model
- Developmental & cognitive capacity
  - Attention span
  - Tolerance for ambiguity
  - Concrete reasoning
  - Capacity for self-reflection
- Impact of symptoms
  - Capacity for concentration
  - Lack of energy & presence of withdrawal
  - Level of anxiety

### Resources

- Friedberg, R.D. & McClure, J.S. (2002) *Clinical Practice of Cognitive Therapy with Children and Adolescents. The Nuts and Bolts*. New York: Guilford Press.
- Greenberger, D. & Padesky, C.A. (1995) *Mind Over Mood. A Cognitive Therapy Treatment Manual for Clients* & same authors, reverse order, *Clinician's Guide to Mind Over Mood*. New York: Guilford Press.